ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD
1740 W. ADAMS ST., SUITE 4600, PHOENIX, ARIZONA 85007
PHONE (602) 364-1PET (1738) FAX (602) 364-1039
VETBOARD.AZ.GOV

COMPLAINT INVESTIGATION FORM

If there is an issue with more than one veterinarian please file a separate Complaint Investigation Form for each veterinarian

PLEASE PRINT OR TYPE

FOR OFFICE USE ONLY

Date Received: Aug. 29, 2019 Case Number: 20-116

A. THIS COMPLAINT IS FILED AGAINST THE FOLLOWING:

Name of Veterinarian/CVT: Deandra Owens

Premise Name: VetMed

Premise Address: 20628 N. Cave Creek Road

City: Phoenix State: AZ Zip Code: 85024

Telephone: (602) 697-4694

B. INFORMATION REGARDING THE INDIVIDUAL FILING COMPLAINT*:

Name: Kandace French Contreras

Address: [redacted]

City: [redacted] State: [redacted] Zip Code: [redacted]

Home Telephone: [redacted] Cell Telephone: [redacted]

**STATE LAW REQUIRES WE HAVE TO DISCLOSE YOUR NAME UNLESS WE CAN SHOW THAT DISCLOSURE WILL RESULT IN SUBSTANTIAL HARM TO YOU, SOMEONE ELSE OR THE PUBLIC PER A.R.S. § 41-1010. IF YOU HAVE REASON TO BELIEVE THAT SUBSTANTIAL HARM WILL RESULT IN DISCLOSURE OF YOUR NAME PLEASE PROVIDE COPIES OF RESTRAINING ORDERS OR OTHER DOCUMENTATION.*

RECEIVED
AUG 29 2019
BY:

C. **PATIENT INFORMATION (1):**

Name: Marvel

Breed/Species: Border Collie Canine

Age: 19 months Sex: Male Color: Tri

PATIENT INFORMATION (2):

Name: _____

Breed/Species: _____

Age: _____ Sex: _____ Color: _____

D. **VETERINARIANS WHO HAVE PROVIDED CARE TO THIS PET FOR THIS ISSUE:**

Please provide the name, address and phone number for each veterinarian.

Deandra Owen, DVM
VetMed
20610 N. Cave Creek Road
Phoenix, Arizona 85024

Another vet on 28th (name unknown)

E. **WITNESS INFORMATION:**

Please provide the name, address and phone number of each witness that has direct knowledge regarding this case.

Reuben Contreras - Co-owner
[redacted]

(See attached for additional witnesses)

Attestation of Person Requesting Investigation

By signing this form, I declare that the information contained herein is true and accurate to the best of my knowledge. Further, I authorize the release of any and all medical records or information necessary to complete the investigation of this case.

Signature: _____

Date: 8/26/19

F. ALLEGATIONS and/or CONCERNS:

Please provide all information that you feel is relevant to the complaint. This portion must be either typewritten or clearly printed in ink.

On June 22, 2019, my 17 month old Border Collie, Marvel, was seen, examined and treated at VetMed for a lacerated rear, right leg with severed Achilles tendon and muscle. Surgery was performed by Dr. Owens.

Marvel was seen again by Dr. Owens and VetMed staff, 2 days post-surgery and then weekly for exam and splint changes on June 25, July 2, July 9, July 16, July 23rd. He was prescribed Remadyl, Gabapentin, and Tramadol.

Since I was not allowed to be present for the procedures, I requested photos sent to me from each appointment. Dr. Owen complied on July 2 and 9. Photos were not sent on July 16th despite my request, and only one photo was provided from the July 23rd appointment.

On July 3, I called VetMed staff because I observed the splint was too short which, A) was not supporting the Achilles tendon, and B) was causing a horizontal cut across the vertical incision and sutures.

On July 22, I requested a refill of the two medications prescribed by Dr. Owen to Marvel, namely Gabapentin and Tramadol. My husband picked up, and paid for, two refill prescriptions. I continued dosing Marvel with a morning and evening dose of each of the two medications provided by VetMed as that had been the prescription history for the past month. Unknown to me at the time, VetMed staff or doctors dispensed Tramadol and Clopidogrel in error. Clopidogrel (Plavix) is a blood thinner, not a sedative/pain reliever. After five days, and as a result of marked changes in Marvel's behavior and physical well-being, I noted the medication was dispensed in error and contacted VetMed.

At the urging of the veterinarian on site; Marvel was hospitalized on July 28th in ICU and given intravenous fluids. I picked him up at 6:15 on the 28th and his splint was wet. It had not been covered during his stay and soaked through to the skin. It had to be replaced by staff not familiar with the splinting procedure for Marvel. The splint had not been covered to prevent it from getting wet and Marvel had urinated all over himself, his splint and his cage, during his stay on IV fluids at VetMed.

Due to the ingestion and overdose of Clopidogrel, I was advised by VetMed staff to discontinue the Tramadol for one week at the recommendation of Poison Control. This further risked additional damage to the repair site due to the inability to provide him with a calming medication. The Vet Tech we spoke with on July 28th that brought Marvel out so told me that she has seen the Clopidogrel, prescribed to a Pit Bull named "Bugs" and owned by Kate and Tyson Weed, sitting around in the back safe for "several weeks" so she was familiar with it. She also said she had seen the Gabapentin prescribed to Marvel sitting in their safe all week and wondered why it was there.

(Continued. See attachment.)

E. Continued
Additional Witnesses

Dr. Bryan Neidigh -
Desert Hills Animal Clinic
039 E Carefree Hwy Ste A, Phoenix, AZ 85085
Phone: (623) 295-0021

Dr. Ross Lirtzman
Animal Specialty Group
7410 E Pinnacle Peak Rd Ste 110, Scottsdale, AZ 85255
Phone: (480) 998-5999

F. Continued
Allegations and/or Concerns:

On July 30, Marvel was seen by my general veterinarian, Bryan Neidigh, to maintain the weekly splint change and wound check schedule. At that time, Dr. Neidigh advised me that Marvel presented with a Level 4 calcaneus pressure sore with bone exposure. Photos were taken. The tissue was necrotic and white and had not been properly treated. Nor had any steps been taken to relieve the pressure from the area.
At no time was I informed of the developing pressure sore from any VetMed staff and no one associated with VetMed took any steps to alleviate or lessen the continuing tissue damage.

On August 1, I consulted with Dr. Ross Lirztman at Animal Specialty Group and on August 6, Marvel began treatment by Dr. Lirztman, including a change in the splint, cleaning and treatment of the pressure sore and ultrasound. Dr. Lirztman advised me that the observation of Dr. Neidigh was accurate regarding the pressure sore. Marvel presented to Dr. Lirztman with a level 4 calcaneus pressure sore with tissue damage, exposed bone, and exposed surgical screw. Photos were taken and the damage documented.

This level of preventable damage is going to extend out the healing process for Marvel by months, in addition to continuous and unnecessary pain. To reiterate, no one from VetMed ever advised me of the sore or the significance. At one time I was told "the sore is not as bad as it looks". But, I assumed the comment was in reference to another sore I pointed out that cut across the incision area due to a too-short splint.

Additionally the ultrasound performed by Dr. Lirztman showed the surgical repair to the tendon was cloudy and inconclusive, with the surgical area unusually tender to the touch. It was not possible to determine if the area of concern is benign, infection, scarring, improper splinting, or complications from the blood thinners.

On August 20th, Dr. Lirztman performed an additional procedure under sedation. The screw and tissue were removed and sent out for a culture due to a clear indication of infection and tenderness at the

surgical site. The culture revealed a staphylococcal infection that could only have been introduced by the VetMed medical personnel, contamination of equipment or devices used during the surgery. Marvel is currently undergoing several weeks of additional antibiotic treatment as a result of the infection.

The time and additional expense incurred in locating and moving Marvel to another physician was extensive. Marvel suffered unnecessary pain and additional damage due to the negligence of the VetMed staff and doctors. Additionally, I continue to incur additional expenses as a direct result of the failure of VetMed staff to follow standard quality control procedures and provide Marvel with an adequate standard of care. VetMed and its staff had a duty to perform an average degree of skill, care and diligence exercised by colleagues practicing under the same or similar circumstances. This did not happen. Marvel and I both suffered physically, emotionally and financially as a result.

The actions and inaction of VetMed as supervised by Dr. Foote and Dr. Owens as a treating veterinarian, was negligent, below the standard of care and risked the life and health of my dog, Marvel. Additionally, I have incurred thousands of dollars in additional costs as a direct result of the negligence of VetMed staff and doctors.

VetMED
EMERGENCY & SPECIALTY CARE

September 17, 2019

Dear Arizona State Veterinary Medical Examining Board,

The following is the narrative account of my position with respect to the events associated with Marvel Contreras' care at VetMED:

Marvel presented to the VetMED ER on 6/22/19 at approximately 7pm. The presenting complaint was a laceration to the right Achilles tendon that occurred when Marvel was caught in a screen door while running to go outside. Marvel was initially examined by the attending emergency veterinarian, Dr. Carol Yeisley. He was noted to be very painful with significant active hemorrhage occurring from the wound. Sedation was administered and a pressure bandage applied.

As the emergency surgeon on this particular weekend, I was already present in the hospital for another patient's emergency surgery. Following completion of this procedure, I was approached by Dr. Yeisley regarding Marvel's injury and asked to consult. I removed the bandage and assessed the wound. A complete laceration of the Achilles tendon was present and active hemorrhage resumed upon removal of the bandage. I explained that while this is not a life threatening emergency, and thus does not require after hours surgery, I would be willing to stay and repair the tendon laceration and overlying wound to prevent contraction of the tendon ends, continued contamination of the wound, and additional pain on the patient's part. By performing the surgery at this time, instead of waiting until the following Monday, I was trying to achieve the best potential outcome for the patient. The owners agreed, and were thankful the procedure was being performed.

Prior to the procedure, I met with the owners personally in an exam room at VetMED. I discussed the procedure, as well as the postoperative stabilization of the tarsus with a calcaneotibial screw to prevent stress on the repair while the tendon heals. Additionally, I explained the limb would be placed in a bandage and a splint to further protect the repair and decrease stress on the screw. The bandage would remain in place for 8 weeks, until the screw was removed under sedation, and the bandage would require weekly bandage changes. The cost of the weekly bandage changes and the implant removal at 8 weeks was not included in the cost of surgery, and payment would be required at each appointment.

During this initial meeting with Mr. and Ms. Condreras, the potential risks and complications of this procedure and recovery were discussed extensively. Issues discussed included screw failure, bone fracture, tendon repair failure, infection, bandage complications, and the need for additional surgery. The owners were informed that tendon healing is slow, and only reaches 80% of the original strength by one year following surgery. They were also informed that the overall prognosis for this injury is typically good in regards to functional recovery, with 70-94% of patients achieving good to excellent function based on the veterinary literature. This conversation was documented in the medical record.

Surgery was performed from 11:30pm on 6/22/19 to 1:09am on 6/23/19. The right Achilles tendon was repaired, but the tendon ends had already started to contract, and it was necessary to fix the tarsus in full extension to appose the lacerated tendon ends. Hemostasis was achieved and the laceration was repaired. Postoperative radiographs were obtained. The location of the calcaneotibial screw was slightly

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more proximal than desired, so the patient was brought back to the OR where another sterile prep was performed, and the screw position was changed to a more desirable location. A second set of postoperative radiographs were obtained, and these confirmed ideal implant placement. A modified Robert Jones bandage with a lateral custom fiberglass splint was placed from the digits to the proximal tibia, and Marvel recovered uneventfully from anesthesia.

Marvel was discharged on 6/23/19 around 5pm. Written discharge instructions were provided. This document also included the potential complications for this injury, and the owner signed the instructions at the time of discharge to acknowledge that she understood the information contained in the document. Rimadyl 1.7mg/kg PO BID, cephalexin 34mg/kg PO BID, gabapentin 20mg/kg PO BID-TID, and trazodone 6.8-10mg/g PO as needed for sedation, up to TID were prescribed. Tramadol was never prescribed, despite Ms. Condreras' statements in her letter.

Marvel returned to VetMED on 6/25/19, 7/2/19, 7/9/19, 7/16/19, and 7/23/19 for bandage changes. The owner requested pictures of the limb be taken and sent to her at each appointment. These pictures were taken and sent to the owner as requested. On 7/16/19, pictures were taken but inadvertently were not sent to the owner (most likely because I simply was busy and forgot to forward them along). All pictures obtained have been included for review.

The exam notes from each bandage change have been included for review. To summarize, the repair was noted to be intact and no complications observed on 6/25/19 and 7/2/19. At 7:40pm on 7/2/19, Ms. Condreras called VetMED to report the most proximal skin suture was visible at the top of the bandage. The nurse she spoke with advised bringing Marvel in through the ER to have the bandage assessed, and if needed, replaced. The owner declined. The following morning on 7/3/19 when I returned to the hospital, I asked a surgery technician to reach out to Ms. Condreras regarding the bandage. This technician left a voicemail recommending the owner send a picture of the bandage and incision so that we may advise appropriately. The owner never responded to this message. Both communications made by VetMED technicians are documented in the medical record.

The next time Marvel returned, on 7/9/19, it was noted that the owner had placed Vet Wrap directly over the skin, without instruction by a veterinarian, over the proximal aspect of the bandage to cover the exposed skin suture. This Vet Wrap was placed circumferentially around the limb at the level of the proximal tibia and stifle. Upon removal of the bandage material, a horizontal dermal sore was present on the caudal aspect of the stifle, coinciding with where the Vet Wrap placed by the owner was cutting into the skin. No additional sores were observed and the repair was intact. After cleaning the sore and applying triple antibiotic ointment, the bandage was replaced. To decrease mechanical irritation to the sore on the caudal aspect of the stifle, a new custom fiberglass splint that was slightly shorter in length was constructed, and the bandage was extended proximal to the stifle. I explained to the owner that typically I prefer not to extend the bandage proximal to the stifle as it is not desirable to immobilize the stifle joint for prolonged periods of time, but I wanted to decrease any mechanical irritation to the wound on the caudal stifle.

At the following appointment on 7/16/19, the bandage was noted to be moderately soiled, wet, and tattered. The previously noted sore caudal to the stifle was healed, the tendon palpated intact, and no other complications were observed. The bandage was replaced as previously stated, and the owner was reminded about appropriate bandage care and activity restriction.

On 7/22/19, the owners called for a refill of Gabapentin and Trazodone. This message was received by Kristin Craig, CVT and lead surgery technician. She filled these medications for the owner to pick up later the same day. When the owner picked the medications up, a client service representative named Jeanne Mikesh inadvertently handed Mr. Condreras Clopidogrel belonging to a patient named Bugs Weed. The instructions on the clopidogrel bottle were to give one 75mg tablet once daily.

On 7/23/19, Marvel presented for a scheduled bandage change. The owners reported no concerns. The bandage was observed as mildly soiled and tattered. Upon removal of the bandage, a dermal sore was noted over the tuber calcanei. The previous sore caudal to the stifle was healed. The sore over the calcaneus was suspected to be a pressure sore, was cleaned with sterile saline and dilute chlorhexidine, and triple antibiotic ointment was applied. A "donut" was created from a foam dressing to alleviate direct pressure to the dermal sore, and the bandage and splint were replaced. Pictures were obtained and emailed to the owner as requested.

On Sunday 7/28/19, Ms. Condreras called VetMED to report she had been giving Marvel clopidogrel. She reported giving him 6-8 doses between 7/22/19 and 7/28/19. She was advised to have Marvel evaluated through the VetMED ER. Marvel was evaluated by Dr. Julia Podmayer on 7/28/19. The incident was reported to the ASPCA Poison Control and the case number is 190132259. Marvel's physical exam was unremarkable, a CBC, chemistry profile, and PT/PTT were performed (results included), and ASPCA Poison Control reported that with the appropriate dose there should be no adverse/detrimental effects from administration at this dose. Marvel received a 4.7mg/kg dose. The recommended dose for dogs is 1-5mg/kg and up to 10mg/kg as a loading dose on day one. Marvel was hospitalized for the day for observation and IV fluids were administered. According to the notes, he ate very well while in hospital, and was discharged later the same day. VetMED covered 100% of the costs related to the medication mistake, which totaled $652.43. At the time of discharge, Marvel's bandage was noted to be wet. The bandage was changed, and upon removal it was observed that the bandage was soaked to the limb. Dr. Podmayer's notes state she was concerned about water exposure prior to his hospitalization. A new bandage was placed.

On 7/29/19, Ms. Condreras called to request Marvel's medical records be sent to Desert Hills Animal Clinic and Animal Specialty Group in Scottsdale. She informed the client service representative that she would no longer be bringing Marvel to VetMED for his care. I received this message on 7/31/19, and called the owner to discuss the medication mistake and her decision to take Marvel elsewhere. There was no answer, so I left a voicemail.

On 8/1/19, Ms. Condreras returned my call. I apologized for the medication mistake and told her I was sorry to see them go as I was really looking forward to following Marvel through his recovery. She relayed that she was very thankful for everything I have done for Marvel throughout this process, especially staying after hours on a Saturday to repair his tendon, and that she did not have a problem with me directly. She explained that she had lost confidence in the hospital because of the medication

mistake. I told her I understood her concerns, and asked if she would mind if I followed up with Dr. Lirtzman regarding Marvel throughout the remainder of the recovery. She said she was fine with me being in contact with Dr. Lirtzman. I once again apologized for the mistake, and let her know we were here if she needed anything.

On 8/19/19, I received a letter sent via certified mail from Ms. Condreras. The letter has been included for review. The letter summarizes her experience through Marvel's surgery and recovery, and is a different letter from the one received by the AZ Veterinary Board. There are many inaccuracies in the letter and they are listed below:

1.) Ms. Condreras states in paragraph two that tramadol was prescribed. Tramadol was never prescribed to Marvel. The medication prescribed was trazodone.

2.) In paragraph 4, the owner states the splint was too short and was not supporting the Achilles tendon. This was the incident on 7/3/19 when the most proximal skin suture was exposed at the top of the bandage. This is incorrect. The splint was appropriately sized, was always supporting the tendon, and was actually made shorter at the following bandage change appointment to prevent mechanical irritation to the skin on the caudal stifle, as stated above. Additionally, the owner was instructed to return to VetMED to have the bandage evaluated when she reported this observation, and did not comply with these recommendations. She also never returned our call or emailed pictures of the bandage, as we requested. She even went as far as to apply bandage material without consulting with a veterinarian and did not return until a week later.

3.) In paragraph 5, she reports that Tramadol and Clopidogrel were dispensed. The medications that were dispensed were Trazodone and Clopidogrel.

4.) In paragraph 6, Ms. Condreras reports the bandage was not covered during his stay in the hospital. It is not routine for bandages to be covered in hospital, unless a patient is repetitively getting the bandage wet, because covering the bandage for prolonged periods of time will trap moisture within the bandage.

5.) In paragraph 7, the owner reports she was told to discontinue tramadol, and it has to be assumed she intends to say trazodone. I did not find this recommendation in the poison control report.

6.) In paragraph 8, Ms. Condreras reports Marvel's primary care veterinarian, Dr. Bryan Neidigh, informed her that Marvel had a "Level 4 calcaneus pressure sore with bone exposure." While a sore in this location had been noted during the bandage change appointment on 7/23/19, it was not to this degree. In paragraph 9, Ms. Condreras reports that she was not informed of this sore and that we did not take steps to alleviate the tissue damage. This is not an accurate statement, as the wound was appropriately cleaned, dressed, and the bandage was placed in a manner to alleviate direct pressure to the sore. Unfortunately, this is a known complication of prolonged bandage application that was discussed at length with Ms. Condreras. Steps were absolutely taken when signs of a sore were observed to decrease the pressure over the sore.

7.) In paragraph 11, Ms. Condreras says the sore caudal to the stifle was caused by the splint being "too short". Again, the splint size was actually decreased when this sore developed to prevent mechanical

irritation to the region. Also, the sore appeared to be caused by the additional Vet Wrap applied circumferentially and directly to the skin by the owner without first consulting a veterinarian. Ms. Condreras did not comply with the recommendation to have Marvel evaluated or send pictures of the bandage.

8.) In paragraph 12, Ms. Condreras says the ultrasound showed the surgical repair to the tendon was "cloudy and inconclusive". She does not report if the ultrasound was performed by a board certified radiologist. Additionally, there are no guidelines in the veterinary literature regarding the ultrasonographic appearance of the Achilles tendon following repair. Lastly, even if there is an infection present, this is also a known potential complication that was discussed with Ms. Condreras at length prior to surgery given there was a large, open wound at the time of the injury. She says it is not known if this "area of concern is benign, infection, scarring, improper splinting, or complications from blood thinners". The mechanism of action of clopidogrel is inhibition of platelet aggregation. There are no veterinary studies that demonstrate adverse wound healing secondary to clopidogrel administration.

9.) In paragraph 13, Ms. Condreras writes VetMED did not provide Marvel with an adequate standard of care, and that both she and Marvel "suffered physically, emotionally, and financially as a result." The medical records clearly document that Marvel received standard of care, and in my opinion, exceeded standard of care as demonstrated by the fact his non-life threatening injury was addressed promptly on a Saturday at midnight by by a board certified surgeon so that Marvel could have the best potential outcome. Pictures were taken and sent to her at her request, which is not routine. Also, it is inaccurate to state the owner has suffered physically and that Marvel has suffered financially.

10.) In paragraph 14, the owner demands to be paid a sum of $5,000 to be "reimbursed for [her] time, expense, and VetMed's failure to treat and prescribe medication to Marvel correctly, causing undue pain and suffering." She continues on to say if this money is not dispersed to her, she will "have no choice but to seek legal remedy through the court and the Arizona State Veterinary Medical Examining Board." The hospital bill regarding the medication mistake was discounted 100%, therefore Ms. Condreras was never financially responsible for this error. Additionally, the bill for the original surgery was $3799.46. The amount of money she is demanding is arbitrary, excessive, and it is unreasonable to provide any additional money to Ms. Condreras after discounting the bill related to the one mistake made by the VetMED staff.

In a separate letter from Ms. Condreras, the letter used in the AZ Veterinary Board complaint, she states that "this level of preventable damage is going to extend out the healing process for Marvel by months, in addition to continuous and unnecessary pain." This has proven to be inaccurate given the amount of recovery time I discussed with the owners was a minimum of 12 weeks. We have not even reached that point yet, and according to Ms. Condreras' Facebook posts on 8/21/19, Marvel is doing well and the pressure sore is healed. The calcaneotibial screw was removed and submitted for culture given it was exposed to the environment through the pressure sore. The culture was reported to have grown a Staph organism based on Ms. Condreras' letter. I do not have a culture report for review. Ms. Condreras reported in the board complaint letter that this infection "could have only been introduced by the VetMED medical personnel, contamination of equipment or devices used in surgery." This statement is not only false, but also exemplifies her complete lack of understanding of surgery, wounds,

implants, and infection. The most likely cause of the staph organism present on the implant are direct contamination from the overlying skin and surrounding wound. The surgical instruments and implants at VetMED are absolutely sterilized appropriately, with indicators of sterilization placed on the outside of the packs, as well as in the deepest portion of the pack. Additionally, regular biologic indicator tests are run on both the steam autoclave and the ethylene oxide unit. Finally, as a board certified surgeon, I can assure you aseptic technique is always followed during hand preparation, gloving, gowning, and surgical site skin preparation. The surgical report for Marvel also documents appropriate aseptic preparation was performed. Marvel had an open wound at the time of surgery. Perioperative antibiotics were administered, the wound was copiously lavaged with sterile saline, and Marvel was discharged with postoperative antibiotics.

Lastly, Ms. Condreras writes in her letter to the board that our care was "negligent, below the standard of care and risked the life and health of my dog, Marvel." Of course I will disagree with this statement, given that I do not believe we were ever negligent or provided care that was below the standard of care. At no time was Marvel's life at risk.

Ms. Contreras was perfectly happy with the care we were providing to Marvel until the unfortunate medication mistake was made. Prior to the medication mistake, and even after when I spoke with her over the phone, she was very thankful for the care I provided to Marvel. The following is a direct quote from an email sent by Ms. Condreras to me on 7/10/19: "I am so appreciative of your talent and effort for our boy." In my opinion, she is using this mistake as an excuse to try and get an excessive amount of money in return. As stated earlier in my report, Ms. Condreras was fully refunded any money directly related to the medication mistake. Fortunately, Marvel did not suffer any complications directly related to clopidogrel and appears to be healing well based on her Facebook posts. The person responsible for handing the wrong medication to the client no longer works here at VetMED and additional measures have been put in place to avoid a similar situation in the future.

Thank you for your time and help with this case, it is greatly appreciated. Please do not hesitate to contact me should you need any additional information regarding Marvel Condreras.

Sincerely,

Deandra J. Owen, DVM

Diplomate, American College of Veterinary Surgeons-Small Animal

Department Head, VetMED Surgery

DOUGLAS A. DUCEY
- GOVERNOR -

VICTORIA WHITMORE
- EXECUTIVE DIRECTOR -

ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD
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INVESTIGATIVE COMMITTEE REPORT

TO: Arizona State Veterinary Medical Board

FROM: AM Investigative Committee: Robert Kritsberg, DVM - Chair
Christina Tran, DVM
Carolyn Ratajack
Jarrod Butler, DVM
Steve Seiler

STAFF PRESENT: Tracy A. Riendeau, CVT – Investigations
Dawn Halbrook – Compliance Specialist
Mary Williams – Assistant Attorney General

RE: Case: 20-16
Complainant(s): Kandace French Contreras
Respondent(s): Deandra Owen, D.V.M. (License: 6993)

SUMMARY:
Complaint Received at Board Office: 8/29/19
Committee Discussion: 11/5/19
Board IIR: 1/15/20

APPLICABLE STATUTES AND RULES:
Laws as Amended August 2018 (Lime Green); Rules as Revised September 2013 (Yellow).

On June 22, 2019, "Marvel," a 19-month-old male Border Collie was presented to Dr. Owen's associate after lacerating his hock. It was determined the Achilles tendon was completely lacerated which Dr. Owen was able to surgically repair that evening. The procedure was performed and the dog was discharged the following day.

The dog returned several times for bandage/splint changes.

On July 22, 2019, Complainant requested refills of the dog's medication.

On July 23, 2019, a pressure sore was noted during the bandage change; it was treated and a bandage was replaced with foam dressing to alleviate direct pressure on the sore.

On July 28, 2019, Complainant reported the dog received Clopidogrel instead of Trazadone and she had given him several doses. The dog was hospitalized for the day on IV fluids and blood was tested. No adverse effects were noted and Complainant was not charged for the treatment.

On August 6, 2019, Complainant presented the dog to Dr. Lirtzman to continue care and treatment of the dog's Achilles tendon repair as she had lost confidence in VETMED.

Complainant was noticed and appeared.
Respondent was noticed and appeared with Counsel, W. Reed Campbell.

The Committee reviewed medical records, testimony, and other documentation as described below:

- Complainant(s) narrative: *Kandace French Contreras*
- Respondent(s) narrative/medical record: *Deandra Owen, DVM*
- Consulting Veterinarian(s) narrative/medical record: *Bryan Neidigh, DVM; Ross Lirtzman, DVM*
- Witness(es) narrative: *Rueben Contreras*

PROPOSED 'FINDINGS of FACT':

1. On June 22, 2019, the dog was presented to Dr. Yeisley at VETMED with a laceration on his leg from getting caught up in a screen door when running to go outside. Upon exam, the dog was in pain and bleeding therefore he was administered butorphanol and acepromazine IM and a pressure bandage was applied to the wound on the right rear leg. It was determined that the dog's Achilles tendon was completely lacerated.

2. Dr. Owen was at the premise for another patient's emergency surgery and was asked by Dr. Yeisley for a consult regarding the dog's injury. Dr. Owen did not feel the laceration was a life threatening emergency therefore it did not require after hours surgery. She stated that she would be willing to stay and repair the tendon laceration and overlying wound to prevent contraction of the tendon ends, continued contamination of the wound, and additional pain.

3. Dr. Owen met with Complainant and her husband to discuss the procedure as well as the post-operative stabilization of the tarsus with a calcaneotibial screw to prevent stress on the repair while the tendon heals. She explained the leg would be placed in a bandage and splint to further protect the repair and decrease stress on the screw. The bandage would remain in place for 8 weeks, until the screw was removed under sedation; the bandage would require weekly bandage changes. The cost of the weekly bandage changes and implant removal was not included in the cost of surgery. Dr. Owen stated that she discussed the potential risks and complications of the procedure and recovery extensively. Issues discussed included screw failure, bone fracture, tendon repair failure, infection, bandage complications, and the need for additional surgery. Dr. Owen explained that tendon healing was slow and only reaches 80% of the original strength by one year following surgery; overall prognosis was 70 -94% of patients achieving good to excellent function. Complainant approved surgery.

4. Pre-surgical blood work was performed and the dog was a surgical candidate. The dog was started on IV fluids, was pre-medicated with glycopyrolate and hydromorphone IV, induced with propofol IV and maintained on isoflurane and oxygen. Cephazolin was administered IV twice during the surgery, and again afterwards. The right Achilles tendon laceration was repaired and stabilized with a calcaneotibial screw; the laceration and hemorrhaging lateral saphenous vascular bundle was also corrected. A bandage and splint were placed for additional support.

5. Dr. Owen called Complainant when the surgery was finished and advised that the surgery took longer than expected; the dog was doing well and could go home the next afternoon if no

complications occurred. Dr. Owen asked that Complainant schedule the bandage change with her.

6. On June 23, 2019, the dog was discharged with written instructions that activity restriction was required for 12 weeks, the bandage had to be kept clean and dry and if it slipped or became wet, Complainant was to have it replaced as soon as possible. The bandage needed to be changed on the 25th and would need to be changed once a week thereafter. Sutures could be removed in 2 weeks during a bandage change. The discharge instructions also outlined possible complications of the surgery. The dog was also discharged with medications: Rimadyl 25mg, Gabapentin 300mg, Cephalexin 500mg, and Trazadone 100mg.

7. On June 25, 2019, the dog was presented to Dr. Owen for a bandage change. The bandage and splint were in place. The bandage was removed and the incision over the calcaneal tendon was clean, dry and intact with sutures in place. There was some soft tissue swelling around the calcaneal tendon. The tendon palpated intact and the tarsus was fixed in extension. There was no evidence of complications and the dog was tolerating the bandage well. Complainant had requested photos of the dog's leg at each bandage change.

8. On July 2, 2019, the dog was presented to technical staff for a bandage change. Mr. Contreras advised that the dog seemed more anxious than usual and was unsure if the dog was getting the Trazadone at home. CVT Ronnebaum changed the dog's bandage and instructed Mr. Contreras to give Trazadone for anxiety; he was to call if it did not help and return in one week for bandage change. Photographs were taken of the dog's leg.

9. According to Dr. Owen, Complainant called later that evening to report that the most proximal skin suture was visible at the top of the bandage. Staff recommended Complainant bring the dog in to assess the bandage; Complainant declined. Communication not found in the medical record as Dr. Owen states in her narrative.

10. On July 3, 2019, Dr. Owen asked her technical staff to contact Complainant regarding the bandage. Staff left a voicemail asking Complainant to send a picture of the bandage and incision so they could advise accordingly. Complainant never responded to the message. Communication not found in the medical record as Dr. Owen states in her narrative.

11. On July 9, 2019, the dog was presented to Dr. Owen for a bandage change. Complainant reported that the dog was walking well at home. However, she had noticed that the bandage was rubbing behind the dog's knee and placed more vetwrap in that location. The dog was evaluated and it was noted that the bandage was moderately soiled and wet at the proximal aspect. There was a 1cm horizontal healed laceration at the proximal aspect of the bandage, caudal to the stifle, in the location of the most proximal skin suture. The incision traveling from proximolateral to distomedial around the tarsus was haled with sutures in place. No soft tissue swelling was present; calcaneal tendon was intact; and tarsus was fixed in hyperextension with no stability or crepitus appreciated.

12. The sutures were removed and the incision was cleaned. A Telfa with triple antibiotic was placed over the healed incision including the proximal bandage sore. The bandage was replaced, extending more proximal to cover the sore with a new, smaller fiberglass splint to

prevent mechanical irritation to the caudal aspect of the stifle. Recommendations were made for the bandage to be changed in one week and to continue to keep the dog's activity restricted.

13. On July 16, 2019, the dog was presented to Dr. Owen for a bandage change. No vitals were taken. The bandage was moderately soiled, wet and tattered at the proximal aspect. The bandage sore was healed as well as the incision. The bandage and splint was replaced and the dog was discharged.

14. On July 22, 2019, Complainant called in a refill of Gabapentin and Trazadone (not Tramadol, as Complainant stated in her complaint) which were filled by CVT Kristin Craig. Later that day the medications were picked up and were given to the pet owner by CSR Jeanne Mikesh who inadvertently gave the pet owner Clopidogrel instead of Gabapentin.

15. On July 23, 2019, the dog was presented to Dr. Owen for a bandage change. The moderately soiled and tattered bandage was removed. There was mild erythema caudal to the stifle but the incision remained healed. There was a full thickness sore over the tuber calcanei (pressure sore) with no gross evidence of infection. The sore was cleaned and a foam dressing donut was place over the pressure sore after placing a Telfa pad with triple antibiotic. The dog was discharged with instructions to return in one week for bandage change.

16. On July 28, 2019, Complainant called to report she had been giving the dog Clopidogrel; she had administered 6 – 8 doses since picking up the medication on 7/22/19. It was recommended the dog be evaluated therefore Complainant presented the dog to Dr. Owen's associate, Dr. Podmayer. The dog was also receiving Trazadone and Rimadyl – Complainant noted the dog had been lethargic and inappetent. Dr. Podmayer examined the dog, performed blood work and reported the incident to poison control.

17. Dr. Podmayer discussed her exam findings, blood results and poison control recommendations with Complainant. The exam was unchanged from last evaluation, blood work was within normal limits and poison control indicated that with the appropriate dose there should be no adverse effects from the administration of Clopidogrel. However, Dr. Podmayer offered to hospitalize the dog at no charge for fluid support and monitoring throughout the day. Complainant agreed and wanted to take him home at the end of the day. After a day of IV fluids and monitoring, the dog was discharged with instructions to discontinue Trazadone for the next week and recheck in one week or sooner if needed. Gabapentin was also filled.

18. According to Dr. Owen discontinuing Trazadone was not recommended in the poison control report. However it is in the discharge instructions from Dr. Podmayer and in Dr. Podmayer's narrative that Complainant was to discontinue Trazadone for the next week.

19. Prior to discharge, the dog knocked over his water bowl therefore his bandage was assessed. The exterior of the bandage was wet and the bandage was removed. Upon removal of the bandage, the underlying padding was soaked through to the dog's skin. Dr. Podmayer was concerned for water exposure prior to the dog presenting to the premises that day. The bandage and splint were replaced using a Telfa, triple antibiotic ointment, and a stockinette donut for comfort along with multiple layers of padding.

20. According to Complainant, the dog's bandage was not covered during hospitalization to prevent it from getting wet. While hospitalized, the dog urinated on himself, the bandage and cage.

21. On July 29, 2019, Complainant requested a copy of the dog's medical records be sent to Desert Hills Animal Clinic and Animal Specialty Group in Scottsdale. She advised VETMED staff that she would no longer be bringing the dog to them for care.

22. On July 30, 2019, the dog was presented to Dr. Neidigh at Desert Hills Animal Clinic for a bandage change. He was advised that Complainant had an appointment with a specialist the following day. Dr. Neidigh removed the dog's bandage and noted a bandage sore on the right lateral hock. A new bandage was placed knowing the dog would be removed the next day by the specialist.

23. According to Complainant, Dr. Neidigh told her that the dog had a level 4 calcaneus pressure sore with bone exposure (Dr. Neidigh's records do not reflect this statement). Photographs were taken; the tissue was necrotic and white and had not been properly treated, nor had any steps been taken to relieve the pressure from the area. Complainant stated that at no time was she informed of the developing pressure sore by VETMED.

24. Dr. Owen stated that a sore in that location had been noted during the bandage change on 7/23/19, but not to that degree. The wound was cleaned, dressed and the bandage was applied in a manner to alleviate direct pressure to the sore. This is a known complication of prolonged bandage application that was discussed at length with Complainant.

25. On July 31, 2019, Dr. Owen left a message for Complainant to discuss the medication mistake and her decision to take the dog elsewhere.

26. Also on this day, the dog was presented to Dr. Lirtzman at Animal Specialty Group of Scottsdale for a second opinion. Since the bandage appeared to be in good condition due to the recent application, the dog was scheduled for a bandage change, limb evaluation and ultrasound of the Achilles tendon on August 6th with Dr. Lirtzman.

27. On August 1, 2019, Complainant returned Dr. Owen's call. Dr. Owen apologized for the mistake and told her she was sorry to see them go and was looking forward to following the dog through his recovery. Complainant was thankful for what Dr. Owen had done for the dog, and did not have a problem with her directly, but had lost confidence in the premises due to the medication mistake. Dr. Owen understood and asked if she could follow up with Dr. Lirtzman throughout the remainder of the dog's recovery. Complainant was fine with Dr. Owen's request.

28. On August 6, 2019, the dog was presented to Dr. Lirtzman for a bandage removal, wound evaluation and tendon ultrasound with rebandage. The bandage was removed and the incision and leg were evaluated – the head of the calcaneo-tibial screw was visible. Ultrasound of the Achilles tendon was performed and showed normal architecture and echogenicity of the mid body of the common tendon and the tendon-bone interface. The laceration repair site was visualized as a large, amorphous, hyperechoic mass without distinct tendon architecture.

Antiseptic wound care and lavage was performed with pressure relieving, padded bandage without splint material. The dog was discharged with instructions to return in 2 days for a recheck.

29. On August 8, 2019, Complainant canceled her appointment with Dr. Lirtzman.

30. On August 13, 2019, the dog was presented to Dr. Lirtzman for bandage change and wound evaluation. The wound was much improved and healthy granulation tissue was present. The previously seen screw head was no longer visible. The wound was cleaned and a new pressure relieving bandage was applied.

31. On August 20, 2019, the dog was presented to Dr. Lirtzman for a bandage change, wound evaluation and possible screw removal with bacterial culture. The wound was much improved at this time. An Achilles tendon ultrasound and radiographs were performed prior to and following screw removal. The ultrasound showed the normal architecture and echogenicity of the mid-body of the common tendon and tendon-bone interface. The laceration repair site was visualized as a smaller, more organized mass but without distinct tendon architecture. Radiographs were diagnostic of minor screw loosening/pull out with both periosteal reactive new bone of the calcaneus and distal tibia as well as tibial endosteal/medullary sclerosis and generalized soft tissue thickening of the tarsus consistent with osteomyelitis.

32. The dog was sedated, the loose screw head was identified with radiographic guidance and a small stab incision was made with screw/washer identification and uncomplicated removal with wound closure. The bone screw was submitted for bacterial culture and post implant removal radiographs were performed. A bandage was place over the implant removal site.

33. On August 26, 2019, Dr. Lirtzman advised Complainant of the implant culture results – staphylococcus pseudintermedius and morazella sp, both susceptible to doxycycline, which was dispensed.

34. On August 29, 2019, sutures were removed and the original open wound over the tuber calcaneus was completely healed with a small scar.

COMMITTEE DISCUSSION:

The Committee discussed that the dog had a catastrophic injury which is associated with a long recovery. There was a mistake made with respect to the wrong medication being dispensed; however, the veterinarians took responsibility, and financial responsibility, for the error. The dog did not appear to suffer from the medication directly or affect the response to therapy.

The premises has made changes to ensure those type of errors do not occur again. Some Committee members felt a violation could be found based on the error.

The Committee discussed that anytime splints/bandages are being used, there is always a risk of sores and infection no matter how responsible the pet owner. The breed is prone to being active; Complainants took good care of the dog and bandages, and there were still times when the bandage was tattered and worn.

COMMITTEE'S PROPOSED CONCLUSIONS of LAW:

The Committee concluded that no violations of the *Veterinary Practice Act* occurred.

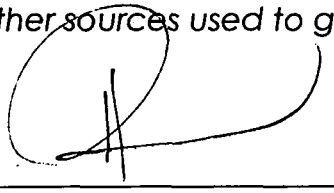
COMMITTEE'S RECOMMENDED DISPOSITION:

Motion: It was moved and seconded the Board:

Dismiss this issue with no violation.

Vote: The motion was approved with a vote of 5 to 0.

The information contained in this report was obtained from the case file, which includes the complaint, the respondent's response, any consulting veterinarian or witness input, and any other sources used to gather information for the investigation.



Tracy A. Riendeau, CVT
Investigative Division